U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 September 2002

In the Matter of

MRS. PATRICIA A. COLVARD,
on behalf, and as widow, of
MR. ROBERT M. COLVARD
Claimant

Case No.: 2001 BLA 668

v.

EASTERN DOMINION COAL COMPANY/
OLD REPUBLIC INSURANCE COMPANY
Employer/Insurer; and,
WESTERN DOMINION COAL COMPANY/
OLD REPUBLIC INSURANCE COMPANY
Employer/Insurer
and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Ron Carson, Personal Representative
For the Claimant

Mr. Joseph W. Bowman, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This matter involves a modification request to a duplicate claim filed by Mr. Robert M. Colvard prior to his death, and a survivor claim filed by Mrs. Patricia A. Colvard, his widow, for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

I conducted a formal hearing in Abingdon, Virginia, on October 3, 2001, attended by Mrs.

Colvard, Mr. Carson and Mr. Bowman. My decision in this case is based on the testimony presented at the hearing and all documents admitted into evidence (DX 1 to DX 121, CX 1, and EX 1).[1]

ISSUES

1. Length of Coal Mine Employment

2. Responsible Operator

3. Mrs. Colvard's Survivor Claim

    A. Whether Mr. Colvard suffered from pneumoconiosis

    B. If Mr. Colvard had coal workers' pneumoconiosis, whether his death was due to pneumoconiosis

4. Mr. Colvard's Miner's Claim

    A. Whether Administrative Law Judge Mollie W. Neal's denial of Mr. Colvard's November 12, 1994 duplicate claim, as affirmed by the Benefits Review Board, should be reconsidered in light of Mr. Colvard's September 25, 1997 and May 13, 1999 requests for modification.

    B. If modification is appropriate, whether Mr. Colvard established a material change in conditions since the denial of his first claim.

    C. If Mr. Colvard established a material change in conditions, whether he was entitled to disability benefits under the Act.

Coal Miner's Background

Born August 24, 1937, Mr. Robert Colvard married Mrs. Patricia Colvard on February 13, 1965 (DX 1 and DX 90-13). He started mining coal as a mine helper in 1973 (DX 1 and DX 2) and continued his work into 1985 when he was laid off (DX 41). Sadly, Mr. Colvard passed away on June 22, 1999 (DX 80).

Procedural Background

Mr. Colvard's Living Miner Claims

[1]The following notations appear in this decision to identify exhibits: DX - Director exhibit; CX - Claimant exhibit; EX - Employer exhibit; ALJ - Administrative Law Judge exhibit, and TR - Transcript of the hearing.

First Claim

Mr. Colvard filed his first claim for benefits under the Act on October 19, 1992 (DX 90-1). The District Director denied his claim on March 17, 1993 for failure to establish pneumoconiosis and total disability due to black lung disease (DX 90-22).

Second Claim

Mr. Colvard filed his second (duplicate) claim on November 12, 1994 (DX 1). On March 22, 1995, the District Director denied the claim for failure to establish total disability (DX 13). Based on Mr. Colvard's April 7, 1995 request for a hearing, the District Director forwarded the case to the Office of Administrative Law Judges ("OALJ") on July 7, 1995 (DX 33). On February 7, 1996, Administrative Law Judge Mollie Neal conducted a hearing regarding Mr. Colvard's second claim (DX 41). On August 22, 1996, Judge Neal denied Mr. Colvard's claim for failure to establish pneumoconiosis and total disability (DX 45). Following Mr. Colvard's appeal of Judge Neal's adverse decision, the Benefits Review Board ("BRB") affirmed Judge Neal's decision on July 3, 1997 (DX 56).

Subsequent to the BRB's decision, Mr. Colvard submitted new medical evidence to support a modification request on September 25, 1997 (DX 57). On June 19, 1998, the District Director denied Mr. Colvard's modification request for failure to demonstrate a mistake in fact or change in conditions (DX 68).

On May 13, 1999, Mr. Colvard filed a second modification request based on a new chest x-ray interpretation (DX 71). A little over a month later, Mr. Colvard passed away and his personal representative forwarded autopsy information to support the modification request (DX 80). On January 13, 2000, the District Director denied Mr. Colvard's request for failure to establish a change in conditions or a mistake of fact (DX 84). On February 2, 2000, Mr. Carson appealed the adverse decision and requested a hearing (DX 86). On May 22, 2000, the District Director forwarded the case to OALJ for a hearing (DX 92). Prior to a hearing, and based on the parties' agreement, the case was remanded on September 18, 2000 to the District Director for the development of additional medical evidence (DX 100). Eventually, the claim was denied and returned on April 10, 2001 to OALJ for a hearing (DX 121). Pursuant to a Notice of Hearing, dated June 4, 2001 (ALJ 1), I conducted a hearing on October 3, 2001.

Mrs. Colvard's Survivor Claim

Mrs. Patricia Colvard filed her claim for survivor benefits on October 31, 2000 (DX 102). On February 8, 2001, the District Director denied Mrs. Colvard's claim because she had not proven the existence of pneumoconiosis in Mr. Colvard's lungs and that pneumoconiosis caused his death (DX 11). On March 12, 2001, Mr. Ron Carson, on behalf of Ms. Colvard, requested a formal hearing before the OALJ (DX 107). The District Director referred the claim to OALJ on April 10, 2001(DX 121) and I held the hearing in conjunction with her husband's claim.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issue No. 1 - Length of Coal Mine Employment

Mr. Colvard claimed about 12 and 1/2 years of coal mine employment while working for Western Dominion ("Western") and Eastern Dominion ("Eastern") Coal Companies (DX 41, page 11). Counsel for the insurer who provided coverage to both companies was willing to stipulate to at least ten years of coal mine employment (DX 41, page 8). Although counsel for the insurer believed the employment records from the two companies indicated Mr. Colvard worked less than one year at Eastern following his lengthy employment with Western (DX 41, page 5), those employment documents are not in evidence.

Both Mr. Colvard's employment history summaries (DX 90-2, DX 90-15) and his hearing testimony (DX 41, pages 10, 11, 13, and 14) consistently indicate that he started coal mining as a helper in October 1973 with Western and continued with that company until March 1984. Then, from May 1984 through May 1985, when he was laid off, Mr. Colvard helped mine coal at Eastern.

The regulation, 20 C.F.R. § 725.101 (a) (32), in defining the term "year," sets out specific guidelines for determining the duration of a coal miner's employment. First, 20 C.F.R. § 725.101 (a) (32) indicates that "year" means a calendar year consisting of either 365 or 366 days, or partial periods totaling one year, during which a miner worked in and around a coal mine for at least 125 working (paid) days. If the miner has worked at least 125 days in a calendar year or "partial periods totaling one year," then he is given credit for one year of coal mine employment, 20 C.F.R. § 725.101 (a) (32) (i). Further, 20 C.F.R. § 725.101 (a) (32)(ii) states the beginning and ending dates of all periods of coal mine employment "shall be ascertained" to the extent permitted by the evidence. Finally, in the absence of beginning and ending dates of coal mine employment, or in calculating partial years, 20 C.F.R. § 725.101 (a) (32) (iii) provides a formula that involves dividing the miner's yearly income by the coal mine industry's average daily earnings for that year to establish the length of coal mine employment.

Based on Mr. Colvard's testimony, I find that he worked ten full years for 1974 through 1983 for Western. Additionally, based on his testimony, corroborated by his 1973 earning from Western of $1,414.06 (DX 4),[2] I give Mr. Colvard three months of work credit for 1973. Likewise, I find based principally on his testimony that Mr. Colvard worked for Western in 1984 the first four months of that year.[3] In summary, while at Western, Mr. Colvard worked a total of ten years and seven

[2]The coal industry's average daily wage for 1973 was $47.19 (See Attachment 1). Thus, Mr. Colvard's 1973 income represents 30 ($1,414.06/47.19) working days, about one quarter of the requisite 125 work days under the regulations.

[3]Mr. Colvard's earnings for 1984 are not particularly helpful, so I rely on his testimony. Notably, since the coal industry's average daily wage in 1984 was $118.40 (*See* Attachment 1), Mr. Colvard's 1984 earnings at Western of $7,728 represent 65 workdays, or about six months of work, at Western. However, he also received

months as a coal miner.

Turning to his employment with Eastern, the parties do not dispute that he was laid off from work in May 1985. Additionally, Mr. Colvard was clear that he started at Eastern in May 1984. As a result, I find Mr. Colvard worked one year and one month at Eastern.

When combining his employment at Western and Eastern, I find Mr. Colvard's total length of coal mine employment was eleven years and eight months.

Issue No. 2 - Responsible Operator

Through the process of determining Mr. Colvard's length of coal mine employment, I have also resolved the issue of responsible operator. Since Mr. Colvard worked one year and one month for Eastern, his last coal mine employer, I find Eastern Dominion Coal Company is the responsible operator in the case. *See* 20 C.F.R. § 725.495

Issue No. 3 - Mrs. Colvard's Survivor Claim

The central issues in Mr. Colvard's two claims and modification requests involved both total respiratory disability and the presence of pneumoconiosis. The later issue is also a principal element of Mrs. Colvard's survivor claim. To facilitate my adjudication of both claims, I will first consider Mrs. Colvard's survivor claim because a favorable finding on the issue of pneumoconiosis in her case would then also establish the necessary change in condition sufficient to satisfy the modification and duplicate requirements associated with the reconsideration of Mr. Colvard's claim.

Under the Act, and the implementing regulations, 20 C.F.R. § 718.205 (a),[4] benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. To obtain benefits, a surviving claimant must prove by a preponderance of the evidence several facts. First, the claimant must establish eligibility as a survivor. A surviving spouse may be considered eligible for benefits under the Act if she was married to, and living with, the coal miner at the time of his death, and has not remarried.[5]

$16,401.77 from Eastern in 1984 which would give him over 125 workdays and credit under the regulations, absent his specific testimony on his employment dates, for one year of employment with Eastern.

[4]Since Mrs. Colvard filed her claim in October 2000, the U.S. Department of Labor has published new regulations concerning black lung disability benefits. Most of the provisions in Part 718 of those new regulations are applicable to her case.

[5]20 C.F.R. § 718.4 indicates that the definitions in 20 C.F.R. § 725.101 are applicable. 20 C.F.R. § 725.101, in turn, refers to the term "survivor" as used in Subpart B of Part 725. 20 C.F.R. § 725.214 then sets out the espousal relationship requirements and 20 C.F.R. § 725.215 describes the dependency rules. According to § 725.214 (a) the spousal relationship exists if the relationship is a valid marriage under state law. Under § 725.215(a), a spouse is deemed dependent if she was residing with the miner at the time of his death.

Next, the claimant must prove the coal miner had pneumoconiosis.[6] "Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment. The regulatory definitions include both clinical pneumoconiosis (the diseases recognized by the medical community as pneumoconiosis) and legal pneumoconiosis (defined by regulation as any chronic lung disease arising out of coal mine employment) 20 C.F.R. § 718.201 (a) (1) and (2). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

Third, once a determination has been made that a miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[8] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[9]

Finally, the surviving spouse has to demonstrate the coal miner's death was due to pneumoconiosis.[10] For a survivor claim filed on or after January 1, 1982, the Department of Labor regulations provide four means to establish that a coal miner's death was due to pneumoconiosis:[11]

1. Death was caused by pneumoconiosis;

2. Death was caused by complications of pneumoconiosis;
3. Pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. Notably, pneumoconiosis is deemed to be a substantially contributing cause of a miner's death if it hastens the miner's death;[12] or,

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[6]20 C.F.R. § 718.205 (a) (1) and *see Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

[7]20 C.F.R. §§ 718.203 (a) and 718.205 (a)(2).

[8]20 C.F.R. § 718.203 (b).

[9]20 C.F.R. § 718.203 (c).

[10]20 C.F.R. § 718.205 (a)(3).

[11]20 C.F.R. §§ 718.205 (c)(1), (2), and (3), and 718.304.

[12]20 C.F.R. §718.205 (c) (5). Previously, the U.S. Court of Appeals for the Fourth Circuit had adopted the U.S. Department of Labor's position that pneumoconiosis substantially contributes to death if it hastens death in any way. *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 979 (4th Cir. 1992), *cert. denied*, 113 S.Ct. 969 (1993). *See also Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3d Cir. 1989) (any condition, such as pneumoconiosis,

4. The miner had complicated pneumoconiosis.[13]

However, a survivor may not receive benefits if the coal miner's death was caused by traumatic injury, or the principal cause of death was a medical condition not related to pneumoconiosis, unless evidence establishes that pneumoconiosis was a substantially contributing cause of death.

In summary, a survivor claim filed after January 1, 1982 must meet four primary elements for entitlement. The claimant bears the burden of establishing these elements by a preponderance of the evidence. If the claimant fails to prove any one of the requisite elements, the survivor claim for benefits must be denied. *Gee v. W. G. Moore and Sons*, 9 B.L.R. 1-4 (1986) and *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). The four elements are: (1) the claimant is an eligible survivor of the deceased miner; (2) the coal miner suffered from pneumoconiosis; (3) the coal miner's pneumoconiosis arose out of coal mine employment; and, (4) the coal miner's death was due to coal workers' pneumoconiosis (caused; complications caused; substantially contributing cause; or complicated pneumoconiosis presumption).

Eligible Survivor

Based on the Colvard's marriage certificate (DX 90-13), Mrs. Colvard's hearing testimony (TR, page 17), and the parties' stipulation of fact (TR, page 29), I find Mrs. Patricia Colvard is an eligible survivor under the Act. Accordingly, Mrs. Colvard has established the first requisite element of entitlement.

Presence of Pneumoconiosis

The next entitlement element that Mrs. Colvard must prove is that Mr. Colvard had pneumoconiosis. According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§718.202 (a)(3)),[14] and physician medical opinion (§718.202 (a)(4)). Since the record does not contain evidence that Mr. Colvard had complicated pneumoconiosis and Mrs. Colvard filed her claim after January 1, 1982, a regulatory presumption of pneumoconiosis is

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that hastens a coal miner's death is a "substantially contributing cause").

[13]According to 20 C.F.R. § 718.304, if a miner had complicated pneumoconiosis, an irrebuttable presumption exists that his death was due to pneumoconiosis.

[14]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

not applicable. As a result, Mrs. Colvard will have to rely on chest x-rays, biopsy/autopsy evidence, and medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Compton*,[15] I must consider the chest x-rays, the biopsy/autopsy evidence, and medical opinion together to determine whether Mr. Colvard had pneumoconiosis.

Chest X-rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
12/9/92	DX 90-21	Navani	Positive for pneumoconiosis, profusion 1/0[16], type s/t opacities,[17] emphysema
(same)	DX 90-20	Sargent, BCR, B[18]	Negative for pneumoconiosis
(same)	DX 90-19	Greene, BCR, B	Negative for pneumoconiosis
12/6/94	DX 8 & DX 10	Paranthaman	Profusion 1/2, type s/t opacities, consistent with asbestosis, not pneumoconiosis
(same)	DX 11	Gaziano	Positive for pneumoconiosis, profusion 1/1, type t opacities
(same)	DX 34	Scott, BCR, B	Emphysema; negative for pneumoconiosis,

[15]*See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

[16]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

[17]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[18]B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

Date of x-ray	Exhibit	Physician	Interpretation
(same)	DX 34	Wheeler, BCR, B	2.5 cm mass right lung; negative for pneumoconiosis
(same)	DX 34	Renn, B	Right lung, ill-defined mass; negative for pneumoconiosis
(same)	DX 36	Wiot, BCR, B	Bilateral, old pleural disease; negative for pneumoconiosis
5/30/95	DX 32	Dahhan, B	Negative for pneumoconiosis, profusion 0/1, type s opacities, emphysema
(same)	DX 34	Fino, B	Markings not pneumoconiosis
(same)	DX 35	Wiot, BCR, B	Extensive bilateral, old, pleural disease; not pneumoconiosis
(same)	DX 37	Shipley, BCR, B	Negative for pneumoconiosis
8/1/97	DX 57	Gopalan	Diffuse interstitial changes
(same)	DX 60	Lippman, B	Positive for pneumoconiosis, profusion 1/1, type t/u opacities; consistent with asbestos exposure
(same)	DX 61	Pathak, BCR, B	Positive for pneumoconiosis, profusion 1/2, type q/t opacities, emphysema; ill-defined mass, right lung
10/16/97	DX 59	Wheeler, BCR, B	Bilateral pleural fibrosis; negative for pneumoconiosis
(same)	DX 59	Scott, BCR, B	Bilateral pleural effusions; negative for pneumoconiosis
(same)	DX 62	Dahhan, B	Emphysema; negative for pneumoconiosis
7/28/98	DX 74	Wheeler, BCR, B	Moderate emphysema; negative for pneumoconiosis
(same)	DX 74	Scott, BCR, B	Negative for pneumoconiosis
9/24/98	DX 71	Westerfield, BCR, B	Positive for pneumoconiosis, profusion 1/1, type q/p opacities; emphysema
(same)	DX 75 & DX 67	Ranavaya, B	Positive for pneumoconiosis, profusion 1/0, type s/t opacities
(same)	DX 79	Wheeler, BCR, B	Negative for pneumoconiosis; possible emphysema
(same)	DX 79	Scott, BCR, B	Negative for pneumoconiosis

Discussion

Of the seven chest x-rays in this case, three films did not cause any dispute among the physicians who reviewed them. The doctors concurred that the films of May 30, 1995, October 16, 1997, and July 28, 1998 are negative for pneumoconiosis.

On the other hand, the medical experts disagree on the remaining films. Although Dr. Navani saw pneumoconiosis in Mr. Colvard's December 9, 1992 chest x-ray, two better qualified radiologists, Dr. Sargent and Dr. Greene, disagreed. Based on the later physicians' qualifications, I find the December 9, 1992 film is negative. Dr. Gaziano observed pneumoconiosis in the December 6, 1994 x-ray. However, his opinion is overwhelmed by the negative interpretations by Dr. Scott, Dr. Wheeler, and Dr. Wiot, dual qualified radiologists, as supported by Dr. Renn and Dr. Paranthaman (who found sufficient profusion but related the markings to asbestosis rather than pneumoconiosis). As a result, the December 6, 1994 x-ray is also negative. Turning to the August 1, 1997 film, Dr. Lippman and Dr. Pathak found pneumoconiosis whereas Dr. Gopalan only saw diffuse interstitial changes. This time, considering Dr. Pathak dual qualified status, I find the August 1, 1997 is positive for pneumoconiosis. The last x-ray taken on September 24, 1998 evenly split the reviewing doctors. Dr. Westerfield, a dual qualified radiologist, and Dr. Ranavaya believed the film was positive. In contrast, Dr. Wheeler and Dr. Scott, both dual qualified radiologists, considered the same film negative for black lung disease. Again, I rely on the concurrence of the two dual qualified radiologists to conclude the September 24, 1998 chest x-ray is negative.

In summary, while the August 1, 1997 chest x-ray is positive for pneumoconiosis, the remaining six films of December 9, 1992, December 6, 1994, May 30, 1995, October 16, 1997, July 28, 1998, and September 24, 1998 are negative for the disease and represent the preponderance of the radiographic evidence. As a result, Mrs. Colvard is unable to establish the presence of pneumoconiosis in her husband's lungs through chest x-rays.

As previously mentioned, although Mrs. Colvard is unable to establish the presence of black lung disease in her husband's lungs by chest x-rays, she still may prevail on this element of entitlement if either biopsy or autopsy evidence supports a finding of pneumoconiosis.

Biopsy/Autopsy

(Note: the following summary, and other remaining portions of this decision, contain detailed information obtained from the autopsy of Mr. Colvard, submitted to support his claim and Mrs. Colvard's survivor claim. While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is necessary because I find the medical information relevant on determining whether Mr. Colvard had pneumoconiosis.)

Prior to reviewing the diverse reports on the examination of Mr. Colvard's lung tissue, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or autopsy helps to understand the significance of some of the reports. The regulations

define "clinical" pneumoconiosis as a condition characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs **and** "the fibrotic reaction of the lung tissue to that deposition," 20 C.F.R. § 718.201 (a) (1) (emphasis added). Such reaction may be characterized as coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silictuberculosis," 20 C.F.R. § 718.201 (a) (1). As a result, an autopsy or biopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202 (a) (2).

Dr. Marcus C. Grimes
(DX 80)

On June 22,1999, Dr. Grimes, a board certified pathologist,[19] conducted an autopsy examination of Mr. Colvard's thorax. Upon gross examination, Dr. Grimes observed dense adhesions over the left lung. The surfaces of both lungs had patches of white fibrous plague that was up to 3 cm thick on the left lung. When sectioning the tissue from the right and left lungs, Dr. Grimes observed "a few" (less than 5% of the surface area) black macules measuring up to 1.5 cm without associated fibrosis. The sections also showed the presence of emphysema.

Under microscopic examination, the lung tissue slides showed bilateral emphysema and carboneaous material present within several macules. At the same time, an iron stain of the slides did not produce signs of asbestos material. Dr. Grimes also found several anthracotic nodules in the lymph node from the left lung.

Since he limited the autopsy to the lungs, Dr. Grimes was unable to state the cause of death. The physician was not aware of Mr. Colvard's work or social histories. He surmised that if Mr. Colvard "was a lifelong coal worker and non-smoker, the scattered macule lesions may represent a very early form of simple (uncomplicated) coal workers' lung pneumoconiosis." Dr. Grimes' final diagnosis was extensive pleural fibrosis, particularly in the left lung, "mildly increased carbonaceous debris (anthracotic pigment) with infrequent macules;" and emphysema.

Dr. Thomas V. Colby
(DX 80)

In September 1999, upon Dr. Grimes' request, Dr. Colby, a board certified pathologist,[20] also examined Mr. Colvard's lung tissue slides. Upon gross examination, Dr. Colby noted "increased anthracotic pigment." Through the microscope, Dr. Colby noted in "some portions of the lung. . .prominent anthracotic pigment and some fibrosis, but it is not in a pattern typical of coal workers'

[19]I take judicial notice of Dr. Grimes board certification and have attached the certification documentation.

[20]I take judicial notice of Dr. Colby's board certification and have attached the certification documentation.

pneumoconiosis, and at this point, I would be reluctant to make an unequivocal diagnosis of pneumoconiosis." If Mr. Colvard had been a non-smoker, then the pigment was related to coal dust. However, if Mr. Colvard had also been a smoker, Dr. Colby would find that fact "a complicating factor to assess the degree and cause of anthracosis." At the same time, Dr. Colby stated that if Mr. Colvard's "occupational history can be confirmed and that there has been significant exposure to anthracotic material," then the lung tissue findings "represent an early atypical form of coal workers' pneumoconiosis."

Based on the extensive pleural fibrosis, Dr. Colby wondered whether a clinical history had established Mr. Colvard's exposure to asbestos. Dr. Colby was not informed of the cause of death, but he assumed "some pulmonary compromise on the basis of the severe visceral pleural fibrosis."

In his final diagnosis, Dr. Colby included prominent anthracosis in both lungs, marked pleural thickening of the left lung, and an intra thoracic lymph node showing anthracosis.

Dr. Richard L. Naeye
(DX 83)

In November 1999, Dr. Naeye, a board certified pathologist,[21] reviewed Mr. Colvard's death certificate, autopsy report, autopsy slides and partial medical history. He noted Mr. Colvard's 12 years of coal mine employment, 7 years exposure to asbestos, and 22 to 40 years of cigarette smoking at the rate of a pack to a pack and a half of cigarettes a day. Additionally, pulmonary function tests from 1997 and 1998 demonstrated Mr. Colvard struggled with an obstructive pulmonary defect.

In the lung tissue, Dr. Naeye observed a small amount of black pigment. However, the pigment was not located in "sites where it characteristically is present in coal workers, i.e. adjacent to small arteries and airways and in the subpleural space." Instead, the black substance in Mr. Colvard's lungs was "admixed in small quantities with large amounts of fibrous tissue in scattered interstitial spaces." Dr. Naeye also noted dense fibrotic plaque with a basket-weave appearance, covered most of the left lung's surface. The right lung also had patches of the plaque. Dr. Naeye suggested asbestos might be a cause of the plaque, but additional testing was necessary. He also observed evidence of chronic bronchitis and mild centrilobar emphysema.

Explaining his diagnosis, Dr. Naeye stated "none of the characteristic lesions of coal workers' pneumoconiosis (CWP) are present in the lung. The black pigment that is present and associated with fibrosis is at interstitial, not peribronchiolar, sites so its location is not compatible with CWP. . . Further CWP does not advance after a miner quits the industry," and Mr. Colvard's shortness of breath developed long after he stopped coal mining in 1985. Additionally, Mr. Colvard's exposure to asbestos seemed insufficient to cause asbestosis. Finally, since CWP was absent, it played no role

[21]I take judicial notice of Dr. Naeye's board certification and have attached the certification documentation.

in Mr. Colvard's disability or death.

Dr. Echols A. Hansbarger
(DX 88)

On March 8, 2000, Dr. Hansbarger, a board certified pathologist, reviewed Mr. Colvard's autopsy report and slides. His microscopic examination revealed emphysema, fibrous pleuritis, focal deposits of anthracotic pigment without reactive fibrosis or coal macules. The bronchial lymph node contained black pigment deposits with reactive fibrosis. Dr. Hansbarger diagnosed moderate centrilobular emphysema, severe chronic fibrous pleuritis, mild focal anthracotic pigmentation, and anthracosilicosis of the bronchial lymph node.

Although the cause of Mr. Colvard's death was unknown, the finding of anthracotic pigmentation was insufficient for a diagnosis of coal workers' pneumoconiosis. Consequently, pneumoconiosis did not contribute to, or hasten, Mr. Colvard's death.

Dr. P. Raphael Caffrey
(DX 89)

In March 2000, Dr. Caffrey, a board certified pathologist, reviewed Mr. Colvard's medical record, including the autopsy report, and examined his lung tissue slides. Tissue from Mr. Colvard's right lung contained evidence of moderate to moderately severe emphysema, pleural plague and very mild amount of anthracotic pigment. The left lung tissue showed moderate emphysema, some anthracotic pigment and thick pleural plaque. Dr. Caffrey did not observe any lesion in the lung tissue that warranted a finding of coal workers' pneumoconiosis. The peribronchial lymph node had anthracotic pigment with a few micro nodules.

Upon review of Mr. Colvard's medical record, in conjunction with the microscopic evaluation, Dr. Caffrey opined that since coal workers' pneumoconiosis was not present, then that lung disease did not contribute to, or hasten, Mr. Colvard's death. Any pulmonary impairment Mr. Colvard may have suffered was due to his cigarette smoking history. The pleural plaque may be caused by exposure to asbestos, but Mr. Colvard did not have asbestosis. Finally, Dr. Caffrey noted that the experts agree that if a person has simple coal workers' pneumoconiosis, it does not worsen after leaving coal mine employment. Mr. Colvard's breathing problems started worsening several years after he quit mining coal.

Dr. Jeffrey A. Kahn
(DX 96, DX 99, and CX 1)

In March 2000, Dr. Kahn, board certified in pathology,[22] also evaluated Mr. Colvard's lung tissue slides and the autopsy report. He found two types of plaque. The first type of plaque developed as a result of a prior inflammation of the lung. The second kind is associated with asbestos exposure. Dr. Kahn also observed emphysema and "a small to moderate quantity of coal dust." Several macules were also present, but in "fewer than 5% of the terminal respiratory units." Dr. Kahn did not see coal macules or massive fibrosis. The lymph nodes had silicotic nodules. Based on his examination, Dr. Kahn diagnosed pulmonary emphysema, pleural fibrosis, and mild simple coal workers' pneumoconiosis.

Discussion

Since the pathologists who examined Mr. Colvard's lung tissue slides disagree on whether pneumoconiosis was present, I must first assess the relative probative value of each medical evaluation and then determine whether Mrs. Colvard is able carry her burden of proving the presence of pneumoconiosis through the preponderance of the more probative pathologist opinion. The two factors I consider in evaluating relative probative weight are: a) documentation and b) reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation, such as chest x-rays, pulmonary function tests, arterial blood gas studies, and physical examinations. *Hoffman v. B & G Construction Company*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor of reasoning involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight . *Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Company*, 11 B.L.R. 1-91 (1988).

In light of his pathological observations, both gross and microscopic, Dr. Grimes' documented and reasoned findings support a conclusion that Mr. Colvard had pneumoconiosis. On gross examination of the lung tissue sections, Dr. Grimes found a few black macules, in about 5% of the surface, measuring up to 1.5 cm. Then, under the microscope, he found these macules contained carboneaous/anthracotic material. Such findings represent both the presence of coal dust particles and the lungs reaction to them. Additionally, Dr. Grimes observed anthracotic nodules in lymph nodes taken from Mr. Colvard's lungs.

[22]I take judicial notice of Dr. Kahn's board certification and have attached the certification documentation.

Presenting both a well documented and reasoned opinion, Dr. Colby generally agreed with Dr. Grimes' observations. Although puzzled by its location in the lung tissue, Dr. Colby was able to define "prominent anthracotic pigment and some fibrosis." He also noted an intra thoracic lymph node which showed anthracosis. Dr. Colby conditioned his diagnosis of pneumoconiosis on an occupational history of significant exposure to coal dust. Mr. Colvard's length of coal mine employment and the description of his work as a coal mine helper fulfill that requisite. Consequently, Dr. Colby's findings, coupled with Mr. Colvard's occupational history, rationally support Dr. Colby's conclusion that Mr. Colvard's lungs contained anthracosis.

Dr. Naeye also reported similar findings. Under the microscope, he observed both black pigment and associated fibrosis. Likewise, he agreed with Dr. Colby that the location of this black pigment was atypical for coal workers' pneumoconiosis. Yet, unlike Dr. Colby, Dr. Naeye relied on the uncharacteristic location of the deposits to conclude Mr. Colvard did not have pneumoconiosis.

At first glance, Dr. Naeye's diagnosis simply represents a different medical conclusion. However, I give his opinion diminished probative value for several reasons. First, based on an additional statement he made to support his conclusion, Dr. Naeye's ability to fully consider the possibility that Mr. Colvard had atypical pneumoconiosis is questionable. According to Dr. Naeye, coal workers' pneumoconiosis does not advance after a miner quits the industry and he noted that Mr. Colvard's breathing problems developed long after he left the mines. Such a position is inconsistent with the regulation which indicates that pneumoconiosis "is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine employment" 20 C.F.R. § 718.201 (c). Second, Dr. Naeye didn't mention, or apparently consider, whether the lung lymph node contained evidence of anthracosis. Consequently, his assessment is not as well documented as the evaluations by Dr. Grimes and Dr. Colby. Third, and closely related, Dr. Naeye's failure to evaluate the lung lymph nodes has an adverse substantive effect, especially in contrast to Dr. Grimes' and Dr. Colby's reports of anthracosis in the lungs lymph nodes, because such a finding may be sufficient to establish the presence of pneumoconiosis. *See Hapney v. Peabody Coal Co.*, 22 BLR 1-104 (2001)(*en banc*), *Clinchfield Coal Co. v. Fuller*, 180 F.3d 622 (4th Cir. 1999) and *Daugherty v. Dean Jones Coal Co.*, 895 F.2d 130 (4th Cir. 1989). Fourth, notably absent in Dr. Naeye's consideration is an alternative explanation for the pigment and fibrosis that he observed. In other words, Dr. Naeye found abnormal lung tissue, determined it was not pneumoconiosis due to its unusual location, and then failed to address what the physical findings might represent instead.

Contrary to the first three pathologists, Dr. Hansbarger did not see any lung reaction to the noted anthracotic pigmentation. And, while he reported the presence of anthracosilicosis in the bronchial lymph node, he still concluded Mr. Colvard did not have pneumoconiosis. Although Dr. Hansbarger's opinion is documented and includes findings from both the lung tissue and lymph node, his opinion is not as well reasoned. Dr. Hansbarger correctly pointed out that anthracotic pigment in the lung tissue is insufficient for a finding of pneumoconiosis, but he failed to consider whether his finding of anthracosilicosis in the lung lymph nodes might still warrant a diagnosis of

pneumoconiosis.[23]

Dr. Caffrey concurred with Dr. Hansbarger's findings. On the basis that the lung tissue contained only anthracotic pigmentation, he concluded Mr. Colvard did not have pneumoconiosis, despite his additional finding of anthracotic pigment associated with micro nodules in Mr. Colvard's peribronchial lymph node. Collaterally, after stating that experts agree simple coal worker's pneumoconiosis does not worsen after a miner quits mining, Dr. Caffrey observed that Mr. Colvard's breathing problems did not start until several years after he stopped mining coal. Thus, though documented, Dr. Caffrey's opinion suffers the same probative deficiency as Dr. Hansbarger's conclusion. His failure to consider the presence of reactive micro nodules in the lymph nodes as evidence of pneumoconiosis renders his conclusion less reasoned. Additionally, to the extent that Dr. Caffrey refers to the non-progressive nature of simple pneumoconiosis to support his conclusion, Dr. Caffrey's assessment has further probative loss in a manner similar to Dr. Naeye's opinion.

Dr. Kahn observed the same features in Mr. Colvard's tissue slides as Dr. Grimes. Over about 5% of the area, macules were observed along with a small to moderate amount of coal dust. However, he also reported the absence of coal macules which, without any further explanation, seems to introduce ambiguity into his opinion. However, Dr. Kahn also reported that the lymph nodes contained reactive nodules, which even standing alone, reasonably supports his diagnosis of mild simple coal workers' pneumoconiosis.

In summary, the six pathologists who evaluated Mr. Colvard's lung and lymph tissue, split evenly on the diagnosis of pneumoconiosis. However, for the reasons discussed above, the opinions of Dr. Naeye, Dr. Hansbarger, and Dr. Caffrey that Mr. Colvard did not have pneumoconiosis have less relative probative weight than the conclusions by Dr. Grimes, Dr. Colby, and Dr. Kahn that Mr. Colvard had coal workers' pneumoconiosis. Accordingly, the preponderance of the more probative pathologists' reports supports a finding of coal workers' pneumoconiosis.

Although I have found that the preponderance of the autopsy/biopsy evidence supports a finding of pneumoconiosis, the court in *Compton* holds that I must further consider the autopsy and biopsy evidence in conjunction with both the radiographic evidence and the other medical opinions in the record.

Turning first to the chest x-rays evidence, I note Dr. Dahhan's statement that autopsy/biopsy evidence is the most definitive means to establish the presence of pneumoconiosis. Consequently, while the preponderance of the chest x-rays are negative for black lung disease, those radiographic studies do not negate a finding of pneumoconiosis based on the more definitive autopsy/biopsy evidence in the record.

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[23]A court has previously, and specifically by name, rejected Dr. Hansbarger's position that a biopsy of a lung lymph node showing anthracosis was insufficient to diagnose pneumoconiosis. *See Daugherty v. Dean Jones Coal Co.*, 895 F.2d 130, 132 (4th Cir. 1989).

Next, in regards to the remaining medical opinions in the record, most of those evaluations were developed prior to Mr. Colvard's death and the subsequent autopsy and are not as well documented or probative as the later medical assessments of Mr. Colvard's pulmonary condition which included consideration of his medical record, radiographic evidence, and the autopsy and biopsy reports. Consequently, in determining whether the preponderance of the medical opinion outweighs a finding of pneumoconiosis based on the autopsy/biopsy results, I will review the more recent opinions of Dr. Dahhan, Dr. Fino, and Dr. Kiser.

Dr. A. Dahhan
(DX 32, DX 40, DX 44, DX 62, DX 65, DX 66, and DX 95)

Dr. Dahhan, board certified in pulmonary disease and internal medicine, first examined Mr. Colvard in 1995. He conducted several other examinations and medical record reviews since then and consistently opined that Mr. Colvard did not have pneumoconiosis. In July 2000, Dr. Dahhan updated his knowledge of Mr. Colvard's case by reviewing the reports of Dr. Caffrey, Dr. Hansbarger, Dr. Colby, and Dr. Grimes. He also considered Mr. Colvard's medical record from 1997 and 1998 plus Dr. Kiser's letter about the cause of Mr. Colvard's death. Based on his review, Dr. Dahhan concluded Mr. Colvard died of a myocardial infarction associated with coronary artery disease. Since the best evidence to determine the presence of black lung disease, lung tissue slides, did not show the presence of pneumoconiosis, coal workers' pneumoconiosis did not cause, contribute to, or hasten, Mr. Colvard's death. Prior to his death, Mr. Colvard was disabled by an obstructive pulmonary impairment and struggled with chronic bronchitis and emphysema, related to his prior consumption of cigarettes.

Dr. Gregory J. Fino
(DX 42, DX 97, DX 98, and EX 1)

Dr. Fino, board certified in pulmonary disease and internal medicine, also evaluated Mr. Colvard's pulmonary condition starting in late 1995. In August 2000, Dr. Fino reevaluated Mr. Colvard's case in light of the 1997 and 1998 medical history, autopsy report, and pathology studies. He noted the more recent medical record established that Mr. Colvard experienced a worsening pulmonary condition that rendered him totally disabled by 1997. However, his deteriorating respiratory health was consistent for a cigarette smoker, but inconsistent for a person with pneumoconiosis because "it is unusual for pneumoconiosis to be progressive." Dr. Fino found no evidence of a coal dust related pulmonary condition and noted that "the autopsy showed no evidence of pneumoconiosis which corroborates my previous opinion that there was no evidence of pneumoconiosis." Due to the limited nature of the autopsy, the exact cause of death is uncertain. However, since Mr. Colvard did not have black lung disease, it was not a factor in his death.

A week later, when asked to consider Dr. Kahn's pathology finding of pneumoconiosis, Dr. Fino responded as follows:

Dr. Kahn found coal macules involving less than 5% of the lung tissue. This

> represents far too mild a pneumoconiosis to account for the man's severe respiratory impairment...Taking this new information into account, it does not cause me to change any of my previously stated opinions. I still believe that the evidence, taken as a whole, does not show that pneumoconiosis was present.

Further, even if pneumoconiosis were present as described by Dr. Kahn, it still played no role in Mr. Colvard's death.

In a September 2001 deposition, Dr. Fino provided further elaboration on Mr. Colvard's pulmonary condition. Although Mr. Colvard had sufficient exposure to coal dust to develop black lung disease, Dr. Fino remained convinced that Mr. Colvard did not have pneumoconiosis. At the same time, due to his long term cigarette smoking history, Mr. Colvard was at risk for emphysema, chronic bronchitis, and lung cancer. Mr. Colvard was prescribed bronchodilators for his breathing problems. That medication is not helpful to treat pneumoconiosis because it is a permanent condition. The more recent pulmonary tests showed Mr. Colvard developed a totally disabling obstructive breathing impairment. Pneumoconiosis played no role in Mr. Colvard's death because the various pathologists either found no evidence of the disease, or just a minimal amount. Such minimal pneumoconiosis was insufficient to adversely impact Mr. Colvard's lungs or contribute in any way to his death. On the other hand, Mr. Colvard's symptoms in the last years of his life were consistent for a person with an extensive cigarette use history.

Dr. Kenneth D. Kiser
(DX 80 and DX 82)

On the day Mr. Colvard passed away, June 22, 1999, Dr. Kiser, his treating physician,[24] signed the death certificate reporting the cause of death as cardiorespiratory arrest due to an MI (myocardial infarction). In October 1999, a few months after signing Mr. Colvard's death certificate, Dr. Kiser stated he treated Mr. Colvard for "multiple years in regard to pulmonary disease, pneumoconiosis, hypertension." His pulmonary condition was very severe and required aggressive treatment. His symptoms included severe shortness of breath coupled with broncho spasms. According to Dr. Kiser, Mr. Colvard died due to "myocardial infarction with coronary artery disease and pneumoconiosis."

Discussion

In considering whether either Dr. Kiser's conclusion supports, or the opinions of Dr. Dahhan and Dr. Fino negate, the finding of pneumoconiosis based on the preponderance of the more probative pathology reports, I find that none of the three opinions sufficiently probative to affect my determination based on autopsy/biopsy evidence.

[24]According to Mrs. Colvard, Dr. Kiser was her husband's treating physician for the last twenty years (TR, page 23).

To support his conclusion, Dr. Dahhan observed that the most probative evidence for determining the presence of black lung disease, lung tissue slides, did not show the presence of pneumoconiosis. However, his opinion has diminished probative value on this issue because, after acknowledging the reports of four pathologists, who had differing opinions about the presence of pneumoconiosis, Dr. Dahhan failed to explain his method or rationale for apparently using the negative reports of Dr. Hansbarger and Dr. Caffrey rather than the positive reports of Dr. Grimes and Dr. Colby. Additionally, as previously addressed in the analysis of the pathologists reports, Dr. Dahhan did not explain his basis for not considering whether the presence of anthracotic material and reactive tissue in the lungs' lymph nodes supports a finding of pneumoconiosis.

Dr. Fino also purported to rely on the pathology reports to support his opinion without explaining his basis for rejecting the positive findings from Dr. Grimes and Dr. Colby. Likewise, Dr. Fino did not address the presence of anthracosis in the lymph nodes. Dr. Fino's final opinion, after considering Dr. Kahn's finding of mild pneumoconiosis, is not well reasoned because he did not explain what other evidence of the record and why such evidence outweighed Dr. Kahn's conclusion and convinced Dr. Fino that Mr. Colvard did not have coal workers' pneumoconiosis.

Finally, Dr. Kiser was in an excellent position as Mr. Colvard's treating physician to provide a probative opinion on the presence of pneumoconiosis. However, his black lung diagnosis without reference to the underlying documentation and the absence of a stated analytical process render his opinion exceptionally non-probative.

In conclusion, I find the opinions of the three physicians who considered both Mr. Colvard's medical record and the post-mortem evidence have little probative value on the issue of whether Mr. Colvard had pneumoconiosis.

Accordingly, when I consider the entire record on this issue, including radiographic interpretations, pathology reports, and medical opinions, I conclude that Mr. Colvard had pneumoconiosis based on the preponderance of the more probative pathology reports of Dr. Grimes, Dr. Colby, and Dr. Kahn. As a result, Mrs. Colvard has proven that the second entitlement element - Mr. Colby had pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven that her husband had pneumoconiosis, Mrs. Colvard must next demonstrate that her husband's pneumoconiosis arose out of his coal mine employment. As indicated earlier, under the regulations, if a miner works ten or more years in one or more mines, a presumption exists that his or her pneumoconiosis arose out of coal mine employment. Earlier in this decision, I determined Mr. Colvard mined coal for nearly twelve years. Thus, since Mr. Colvard had more than

ten years of coal mine employment, and in the absence of sufficient evidence to the contrary,[25] I find his pneumoconiosis arose out of his coal mine employment.

Death Due to Pneumoconiosis

With the first three elements of entitlement proven, Mrs. Colvard may receive survivor benefits if the preponderance of the evidence in the record establishes that her husband's death was due to pneumoconiosis. To prove this last element of entitlement, Mrs. Colvard must show Mr. Colvard's death was due to pneumoconiosis. As previously discussed, death due to pneumoconiosis may be proven by showing: 1) Mr. Colvard had complicated pneumoconiosis; 2) Mr. Colvard's death was caused by pneumoconiosis; 3) complications of pneumoconiosis caused his death; or, 4) pneumoconiosis was a substantially contributing cause or factor leading to his death (hastened his death).

Complicated Pneumoconiosis

Under the regulations, 20 C.F.R. § 718.304, a massive lesion in the lungs that qualifies as complicated pneumoconiosis establishes an irrebuttable presumption that the coal miner's death was due to pneumoconiosis. Mr. Colvard's radiographic and pathologic record does not establish the presence of such a large lesion or complicated pneumoconiosis. As a result, Mr. Colvard did not have complicated pneumoconiosis and his surviving wife may not rely on this means of demonstrating that his death was due to pneumoconiosis.

Death Caused By Pneumoconiosis

The record contains insufficient evidence to conclude that pneumoconiosis killed Mr. Colvard. First, Dr. Kiser, his treating physician, indicated on Mr. Colvard's death certificate that cardiorespiratory arrest due to a possible myocardial infarction was the immediate cause of death. Additionally, due to the limited nature of the autopsy, none of the other physicians (Dr. Grimes, Dr. Colby, and Dr. Kahn), who concluded Mr. Colvard had pneumoconiosis and considered the circumstances of his death, could indicate that pneumoconiosis was the cause of death.[26] In light of the evidentiary insufficiency, I find Mr. Colvard's death was <u>not</u> caused by pneumoconiosis.

Death Caused By Complications Of Pneumoconiosis

Mrs. Colvard may still receive benefits as a survivor if her husband's death was caused by complications of pneumoconiosis. Only Dr. Kiser (by implication) in his October 1999 statement

[25]Although Dr. Colby expressed some reservations about the source of the anthracosis, the other pathologists who found the presence of pneumoconiosis in Mr. Colvard's lung tissue did not question its etiology.

[26]The other doctors who evaluated the cause of death (Dr. Naeye, Dr. Hansbarger, Dr. Caffrey, Dr. Dahhan, and Dr. Fino) did not believe Mr. Colvard had pneumoconiosis which is contrary to my finding and renders their consensus that pneumoconiosis did not cause his death meaningless on this issue.

indicates a belief that complications of pneumoconiosis may have caused Mr. Colvard's death. However, Dr. Kiser's conclusion is accompanied by neither the documentation that he used to reach it nor the rationale for his diagnosis and statement. The absence of both factors is significant in this case since even the pathologists who observed evidence of pneumoconiosis in the tissue slides characterized its extent as few, mild, some, or 5% of the tissue. As a result, Dr. Kiser's opinion, despite his status of treating physician, does not establish that Mr. Colvard's death was caused by complications of pneumoconiosis.

Pneumoconiosis Was a Substantially Contributing Cause Of, Or Hastened, Death

Even though neither pneumoconiosis nor its complications caused Mr. Colvard's death, Mrs. Colvard may still be entitled to survivor benefits if pneumoconiosis was a substantially contributing cause of, or hastened her husband's death. In other words, if pneumoconiosis cut short Mr. Colvard's life in any manner, Mrs. Colvard may prevail with her survivor claim.

Dr. Kiser's observation that he treated Mr. Colvard for severe shortness of breath might raise an inference that pneumoconiosis hastened Mr. Colvard's death. Regardless of whether such an inference may be sufficient proof of this issue, it loses any probative value due to absence of documentation or an explanation linking Mr. Colvard's shortness of breath from black lung disease to his demise.

After indicating that he was unaware of the cause of death, Dr. Colby surmised that some pulmonary compromise was involved in Mr. Colvard's death. However, and significantly, Dr. Colby also indicated the compromise would be due to the severe pleural fibrosis observed in the post-mortem examination of Mr. Colvard's lungs. Since none of the pathologists linked that severe fibrosis to Mr. Colvard's coal mine employment, it did not amount to pneumoconiosis. Thus, Dr. Colby's observations do not support a finding that complications of black lung disease contributed to Mr. Colvard's death.

Finally, although Dr. Fino concluded Mr. Colvard did not have pneumoconiosis, he also observed that Dr. Kahn's finding of mild pneumoconiosis involving 5% of the lung tissue area was minimal to the extent that it would have had no effect on Mr. Colvard's pulmonary condition.

In summary, due to the absence of sufficient probative medical opinion on this issue, I find pneumoconiosis was not a substantially contributing factor in Mr. Colvard's passing, and it did not hasten his death.

Conclusion

Although Mrs. Patricia A. Colvard is an eligible survivor under the Act and her husband, Mr. Robert M. Colvard, had pneumoconiosis due his coal mine employment, the record contains insufficient evidence to establish that his death was caused by pneumoconiosis, or as a consequence of coal worker's pneumoconiosis. Additionally, the medical record fails to prove that coal workers'

pneumoconiosis substantially contributed to, or hastened his death. Accordingly, Mrs. Colvard has failed to carry her burden of proof to establish that Mr. Colvard's death was due to pneumoconiosis and her claim for survivor benefits under the Act must be denied.

Issue No. 4 - Mr. Colvard's Miner Claim

Modification and Duplicate Claim

Mr. Colvard's first claim was denied in 1993 for failure to establish either the presence of pneumoconiosis or a total disability. When Judge Neal denied Mr. Colvard's second (duplicate) claim in 1996, she reached the same conclusion - the evidence remained insufficient to establish either the presence of black lung disease or total disability. Mr. Colvard 's first modification was denied in 1998 for essentially the same reason.

Now, with Mr. Colvard's second modification request, and based on my findings during the consideration of Mrs. Colvard's survivor claim, Mr. Colvard has, posthumously, demonstrated the presence of pneumoconiosis in his lungs. As a result, a change in condition has occurred since the denial of his first modification request which makes reconsideration of that denial and Judge Neal's denial of his duplicate claim appropriate. *See* 20 C.F.R. §§ 725.309 (c) and 725.310. Upon reconsideration of Judge Neal's decision, and again based on my finding that Mr. Colvard had pneumoconiosis, he has also established a material change in conditions since the denial of his first claim. *See* 20 C.F.R. § 725.309 (d). Consequently, the entire record must be evaluated to determine whether Mr. Colvard was entitled to disability compensation under the Act.

To receive compensation under the Act, a miner must prove four basic elements by a preponderance of the evidence. First, the miner must establish the presence of pneumoconiosis. Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the pneumoconiosis arose, at least in part, out of coal mine employment.[27] Third, the miner has to demonstrate he is totally disabled.[28] And, fourth, the miner must prove the total disability is due to pneumoconiosis.[29]

Presence of Coal Workers' Pneumoconiosis

In my adjudication of Mrs. Colvard's survivor claim, I have determined that Mr. Colvard had pneumoconiosis due to his coal mine employment.

Total Disability

[27]20 C.F.R. § 718.203 (a).

[28]20 C.F.R. § 718.204 (b).

[29]20 C.F.R. § 718.204 (a).

The third necessary element for entitlement of benefits is total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. § 718.204 (b) (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area (20 C.F.R. § 718.204 (b) (1)).

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. The U.S. Court of Appeal for the Third Circuit has held that, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling, separate, and apart from other non-respiratory conditions.[30]

The record does not contain evidence of complicated pneumoconiosis or cor pulmonale with right-sided congestive heart failure. Accordingly, Mr. Colvard must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	**Date/ Doctor**	**Age/ height**	**FEV_1 pre[31] post[32]**	**FVC pre post**	**MVV pre post**	**$\%FEV_1$/ FVC pre post**	**Qualified[33] pre post**	**Comments**

[30]*See Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995).

[31]Test result before administration of a bronchodilator.

[32]Test result after administration of a bronchodilator.

[33]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV_1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV_1/FVC has to be equal or less than 55%.

DX 90-14	Dec 9, 1992 Dr. Kapadia	55 68"	2.41 2.21	3.66 3.57	98 99	66 62	No[34]	Mild obstruction
DX 7	Dec. 6, 1994 Dr. Paranthaman	57 68"	2.06 2.15	3.38 3.53	100 110	60.9 60.9	No[35]	Good effort, good cooperation
DX 66	May 30, 1995 Dr. Dahhan	57 68"	2.18 2.34	3.54 4.14	104 102	62 56	No	Mild reversible obstruction
DX 57	Aug 4, 1997 Dr. Sy	59 68"	1.04 1.14	2.25 2.34	37 41	48 49	Yes[36]	Moderate obstruction Not acceptable per Dr. Michos (DX63)
DX 65 & DX 66	Oct 16, 1997 Dr. Dahhan	60 68"	1.08 1.15	2.51 2.75	40 44	43 42	Yes[37]	Partially reversible, severe obstruction Acceptable per Dr. Michos (DX 66)
DX 71	Jul 20, 1998 Dr. Craven	60 68"	1.66	2.77		60	No	Moderate obstruction
DX 71	Sep. 24, 1998 Dr. Emery	61 68"	1.34 1.34	2.91 2.96		46 45	Yes[38]	Non-reversible severe obstruction

Arterial Blood Gas Studies

Exhibit	**Date/ Doctor**	**$_PCO_2$** (rest) **$_PCO_2$** (exercise)	**$_PO_2$** (rest) **$_PO_2$** (exercise)	**Qualified**[39]	**Comments**
DX 90-18	Dec. 9, 1992 Dr. Kapadia	41.6	71.4	No[40]	

[34]The qualifying FEV_1 number is 1.98 for age 55 and 68".

[35]The qualifying FEV_1 number is 1.95for age 57and 68".

[36]The qualifying FEV_1 number is 1.92 age 59 and 68". The associated qualifying FVC and MVV values are 2.44 and 77, respectively.

[37]The qualifying FEV_1 number is 1.90 age 60 and 68". The associated qualifying FVC and MVV values are 2.43 and 76, respectively.

[38]The qualifying FEV_1 number is 1.89 age 61 and 68". The associated qualifying FVC and MVV values are 2.41 and 76, respectively.

[39]Under 20 C.F.R. § 718.204 (b) (2) (ii), to qualify for Federal Black Lung disability benefits at a coal miner's given $_PCO_2$ level, the value of the coal miner's $_PO_2$ must be equal to or less than corresponding $_PO_2$ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[40]For the $_PCO_2$ values of 40 to 49, the qualifying $_PO_2$ is 60.

DX 9	Dec 6, 1994 Dr. Paranthaman	41 35	63 71	No No[41]	Mild resting hypoxemia
DX 57	Aug 4, 1997 Dr. Sy	42	51	Yes	Moderate hypoxemia
DX 66	Oct 16, 1997 Dr. Dahhan	42.7 44.9	55 59.4	Yes Yes	Severe hypoxia at rest Moderate hypoxia with exercise
DX 71	Sep 24, 1998 Dr. Emery	40.2	57	Yes	

The preponderance of the conforming, pulmonary function tests since August 1997 (two of three tests) establishes total disability under the regulations. Similarly, all of the blood gas studies conducted since August 1997 (three) demonstrate a totally disabling blood gas impairment. Through both pulmonary function tests and blood gas studies, Mr. Colvard has proven that at least since August 1997 he was totally disabled by a pulmonary and respiratory impairment.

Total Disability Due to Pneumoconiosis

Because Mr. Colvard has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not, by itself, establish the impairment is due to pneumoconiosis. Absent regulatory presumptions in favor of the claimant,[42] the miner must under 20 C.F.R. § 718.204 (c) (1) demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease for exposure unrelated to pneumoconiosis.

Since Mr. Colvard did not have complicated pneumoconiosis and he filed his present claim after 1982, he would not be able to rely on any of the regulatory presumptions. Instead, Mr. Colvard must use medical opinion in the record to establish that his total disability is due to pneumoconiosis. *See* 20 C.F.R. § 718.204 (c) (2). In that regard, while I have summarized all the medical opinions below, the more relevant evidence on the etiology of Mr. Colvard's disability are the assessments completed since August 1997, when objective medical evidence (pulmonary function tests and arterial blood gas studies) demonstrated total disability.

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[41]For the $_{P}CO_2$ value of 35, the qualifying $_{P}O_2$ is 65.

[42]20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Medical Opinion[43]

Dr. P.B. Kapadia
(DX 90-15 and DX 90-17)

On December 9, 1992, Dr. Kapadia administered an examination of Mr. Colvard's pulmonary condition. Mr. Colvard reported 12 years of coal mine employment. He also smoked about 20 cigarettes a day for 40 years, from 1952 to 1992. Upon physical examination, Mr. Colvard's chest was clear. The chest x-ray was positive for pneumoconiosis and emphysema. Minimal hypoxia was established by the blood gas study. The pulmonary test indicated a mild obstructive flow pattern. Dr. Kapadia diagnosed emphysema due to cigarette smoke and early stage pneumoconiosis. The obstruction caused a mild impairment that did not preclude his return to coal mining.

Dr. S.K. Paranthaman
(DX 8)

On December 6, 1994, Dr. Paranthaman examined Mr. Colvard. At that time, the former miner indicated he worked in the coal mines about 12 years and had smoked about 1 and 1/2 packs of cigarettes a day for about 22 years. The physical examination disclosed bilateral, decreased breath sounds. The chest x-ray showed type t opacities consistent with asbestosis, and Mr. Colvard's work as a plaster from 1955 to 1962. The pulmonary function tests indicated a mild to moderate airway obstruction and the blood gas studies showed moderate resting hypoxemia. Dr. Paranthaman concluded Mr. Colvard had asbestosis and not coal workers' pneumoconiosis. He had a borderline respiratory capacity to return to coal mine employment as either a shuttle car operator or mine helper.

Dr. A. Dahhan
(DX 32, DX 40, DX 44, DX 62, DX 65, DX 66, and DX 95)

On May 5, 1995, Dr. Dahhan, board certified in pulmonary disease and internal medicine, examined Mr. Colvard. Mr. Colvard stated that he had worked 12 years in the coal mines as a continuous miner operator, shuttle car operator, and mine helper. He also started smoking when he was 15 at the rate of about 2 packs a day for 40 years. Dr. Dahhan heard expiratory wheezes. The chest x-ray showed emphysema and was insufficient for a diagnosis of pneumoconiosis. Mr. Colvard had moderate hypoxia and a mild pulmonary obstruction. Based on the lung diffusion test results and the improvement in his blood gases upon exercise, Mr. Colvard was not totally disabled. Dr. Dahhan did not believe Mr. Colvard's pulmonary problems were due to coal dust since he did not have a pulmonary restriction and blood gases improved upon exercise.

In November 1995, Dr. Dahhan also conducted a medical record review. In addition to

[43]I have not included the opinions of Dr. Grimes, Dr. Colby, Dr. Naeye, Dr. Hansbarger, Dr. Caffrey, and Dr. Kahn since their expertise was focused on Mr. Colvard's death and the presence of pneumoconiosis. None of these doctors commented on whether Mr. Colvard was totally disabled prior to his death.

considering the results of his May 1995 evaluation of Mr. Colvard's pulmonary condition, Dr. Dahhan reviewed the pulmonary examination reports of Dr. Paranthaman (December 1994) and Dr. Kapadia (December 1992). All three physicians reported his coal mine employment as 12 years and his cigarette smoking history varied from a pack a day for 22 years to 80 pack years.[44] The physical examinations disclosed scattered expiratory wheezes. Although the preponderance of the chest x-rays were negative for pneumoconiosis, the radiographic films revealed hyper inflated lungs. Dr. Dahhan concluded there was insufficient evidence of pneumoconiosis. He observed that the obstructive pulmonary defect established by the pulmonary function tests had a reversible component. Further, Mr. Colvard's blood gas test results improved upon exercise. Both results are inconsistent with permanent lung damage due to pneumoconiosis. Due to the length of time since his departure from coal mining, Mr. Colvard's obstruction was not industrial bronchitis. Instead, Mr. Colvard had a chronic obstructive lung problem due to his long cigarette smoking history which would preclude his return to heavy manual labor.

In a January 1996 deposition, Dr. Dahhan provided further elaboration on his assessment of Mr. Colvard's respiratory impairment. After acknowledging his understanding about the definitions of legal and medical pneumoconiosis, Dr. Dahhan stated that Mr. Colvard's obstructive defect was not related to his exposure to coal dust because it developed several years after he left coal mining (and thus was not industrial bronchitis) and responded to bronchodilators. Although Mr. Colvard's 12 years of coal mine employment was sufficient to put him at risk for developing black lung disease, Dr. Dahhan also observed that if a miner didn't have pneumoconiosis at the time he left the coal mines, he was unlikely to develop black lung in the future. On the other hand, Mr. Colvard's pulmonary problems were consistent with his long term history of cigarette smoking. Since Mr. Colvard's blood gas studies show a normal response to exercise, he was not totally disabled due to a respiratory impairment.

Dr. Dahhan conducted another pulmonary examination in October 1997 and reviewed Mr. Colvard's medical record. Upon Mr. Colvard's expiration of air, Dr. Dahhan heard wheezes. The chest x-ray showed hyper inflated lungs. According to the blood gas studies, Mr. Colvard had severe hypoxia at rest, which improved to moderate hypoxia upon exercise. His pulmonary function tests showed a severe obstructive defect which Dr. Dahhan attributed to long term cigarette smoking. Dr. Dahhan did not believe Mr. Colvard had pneumoconiosis because: the chest x-ray was negative; Mr. Colvard's pulmonary defect was strictly obstructive; Mr. Colvard's obstructive defect was reversible upon administration of bronchodilators; and, Mr. Colvard's blood gases improved upon exercise. Finally, Dr. Dahhan concluded Mr. Colvard did suffer a totally disabling respiratory impairment.

Following Mr. Colvard's death, and upon review of the pathology reports, Dr. Dahhan remained convinced that Mr. Colvard did not have pneumoconiosis.

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[44]A pack year equals the consumption of one pack of cigarettes a day for one year. Mr. Colvard reported on multiple occasions that he smoked one and a half to two packs of cigarettes a day for 40 years starting when he was 15.

Dr. Gregory J. Fino
(DX 42)

In December 1995, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted a review of the December 1992, December 1994, and May 1995 pulmonary examinations. The preponderance of the chest x-ray interpretations were negative. He observed that the pulmonary function tests, based on reduced small airways flow, showed the obstruction existed in the small airways, which is consistent with emphysema associated with cigarette smoking. The tests also showed Mr. Colvard's lung tissue was expanded due to the trapped air caused by the obstructive defect. That situation was inconsistent with pneumoconiosis which causes a contraction of the lung tissue due to fibrosis. Mr. Colvard's obstruction had no restrictive component and responded to bronchodilators. For these reasons, Dr. Fino found the record insufficient to diagnose pneumoconiosis. He also concluded Mr. Colvard was not totally disabled due to his pulmonary defects.

Upon review of Mr. Colvard's medical record from 1997 and 1998, Dr. Fino opined that he had become disabled by 1997. However, Dr. Fino attributed the disability to Mr. Colvard's cigarette smoking habit and observed that it was unusual for pneumoconiosis to be progressive.

Dr. Alexander O. Sy
(DX 57)

On August 1, 1997, Dr. Sy evaluated Mr. Colvard for black lung disease. Mr. Colvard reported a little less than 12 years of coal mine employment and the consumption of a pack to two packs of cigarettes a day for 31 years. At that time, Mr. Colvard struggled with shortness of breath upon exertion. Although, Dr. Sy heard normal breath sounds, the pulmonary function tests indicated a moderate obstruction and the blood gas study showed moderate hypoxemia. Dr. Sy diagnosed chronic bronchitis, hypertension, and coal workers' pneumoconiosis.

Dr. Joseph F. Smiddy
(DX 71)

On August 31, 1998, Dr. Smiddy, board certified in internal medicine, examined Mr. Colvard, who complained about shortness of breath. Aged 61 years old, Mr. Colvard reported 12 years of coal mine employment and 6 years exposure to asbestos as a plaster. He started smoking cigarettes when he was 15 and stopped in 1992. Dr. Smiddy heard a few rales in Mr. Colvard's chest and observed that a contemporaneous chest x-ray showed signs of pneumoconiosis and bilateral pleural scarring. Dr. Smiddy diagnosed pneumoconiosis, asbestosis, emphysema, COPD (chronic obstructive pulmonary disease), and chronic bronchitis.

Dr. Kenneth D. Kiser

In October 1999, Dr. Kiser indicated that he had been treating Mr. Colvard's pulmonary disease and pneumoconiosis for several years. Mr. Colvard's pulmonary condition was severe and consisted of severe shortness of breath and broncho spasms.

Discussion

In weighing the relative probative weights of the diverse medical opinion, I first find the evaluations of Dr. Kapadia and Dr. Paranthaman are not particularly helpful since they reached their opinions prior to the establishment of Mr. Colvard's total disability.

Next, because I have determined that Mr. Colvard had pneumoconiosis, Dr. Dahhan's persistent opinion that Mr. Colvard did not have pneumoconiosis is clearly inconsistent with my finding and significantly diminishes the probative value of his conclusion that Mr. Colvard was not disabled by pneumoconiosis.

Dr. Smiddy and Dr. Sy recognized Mr. Colvard's struggle with breathing, his extensive cigarette use, chronic obstructive breathing defect, and the presence of pneumoconiosis. However, neither doctor specifically found Mr. Colvard totally disabled from his former work as a coal miner or directly addressed the role pneumoconiosis played in Mr. Colvard's impairment. This shortfall is important since Mr. Colvard has the burden to show that pneumoconiosis was a significant contributing factor and considering his exposure to asbestos and extensive cigarette smoke, in addition to coal dust. Further, because these physicians did not review the postmortem evidence, in particular, the findings concerning the degree of pneumoconiosis found in Mr. Colvard's lung tissue, their opinions are also not well documented. Consequently, their evaluations are not helpful in determining whether Mr. Colvard was totally disabled due to pneumoconiosis.

Initially, Dr. Fino's assessment almost suffers the same probative fate as Dr. Dahhan's evaluation since he did not believe Mr. Colvard had pneumoconiosis. Yet, based on some of the pathology reports, Dr. Fino also observed that even if Mr. Colvard did have pneumoconiosis, the positive biopsy findings showed its extent to be minimal such that it would not have adversely impacted Mr. Colvard's lungs. Thus, I consider this portion of Dr. Fino's opinion to be somewhat probative concerning the causation of Mr. Colvard's total disability.

Finally, Dr. Kiser treated Mr. Colvard for a severe pulmonary condition and diagnosed both a pulmonary disease and pneumoconiosis. However, in his terse statement, Dr. Kiser did not address the specific causation of the pulmonary problems. As I have already discussed, his opinion is not well documented or reasoned. Again, considering the multiple pulmonary risks that Mr. Colvard encountered in his life and minimal extent of pneumoconiosis found in the autopsy tissue slides, Dr. Kiser's silence on causation, underlying documentation, and reasoning reduces the probative value of his opinion and does not support a finding of total disability due to pneumoconiosis.

Conclusion

Having evaluated all the medical opinion in the record, I find that Dr. Fino's determination that pneumoconiosis would not have caused an adverse effect on Mr. Colvard's pulmonary condition better documented and partially reasoned than Dr. Kiser's statement about Mr. Colvard's severe pulmonary condition, especially since the presence of a totally disabling impairment by itself does not establish that the disability is due to pneumoconiosis. The preponderance of the medical opinion does not demonstrate Mr. Colvard's pneumoconiosis was a substantial factor in his total respiratory impairment. Thus, since Mr. Colvard bore the burden of proving all four elements of entitlement and has not proven the fourth requisite element, total disability due to pneumoconiosis, his claim for benefits must also be denied.

ORDER

1. The claim of MRS. PATRICIA A. COLVARD for survivor benefits under the Act is **DENIED**.

2. The claim of MR. ROBERT M. COLVARD for disability benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 4, 2002
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice

of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

ATTACHMENT 1
COAL MINE (BLBA) PROCEDURE MANUAL
AVERAGE EARNINGS OF EMPL0YEES IN COAL MINING

Year	*Yearly (125 days)*	*Daily*
1999	$19,340.00	$154.72
1998	19,160.00	153.28
1997	19,010.00	152.08
1996	18,740.00	149.92
1995	18,440.00	147.52
1994	17,760.00	142.08
1993	17,260.00	138.08
1992	17,200.00	137.60
1991	17,080.00	136.64
1990	16,710.00	133.68
1989	16,250.00	130.00
1988	15,940.00	127.52
1987	15,750.00	126.00
1986	15,390.00	123.12
1985	15,250.00	122.00
1984	14,800.00	118.40
1983	13,720.00	109.76
1982	12,698.75	101.59
1981	12,100.00	96.80
1980	10,927.50	87.42
1979	10,878.75	87.03
1978	10,038.75	80.31
1977	8,987.50	71.90
1976	8,008.75	64.07
1975	7,405.00	59.24
1974	6,080.00	48.64
1973	5,898.75	47.19
1972	5,576.25	44.61
1971	5,008.75	40.07
1970	4,777.50	38.22
1969	4,261.25	34.09
1968	3,801.25	30.41
1967	3,662.50	29.30
1966	3,438.75	27.51
1965	3,222.50	25.78
1964	3,031.25	24.25
1963	2,835.00	22.68
1962	2,717.50	21.74
1961	2,645.00	21.16

Bituminous **Anthracite**

Year	Yearly	Daily	Yearly	Daily
1960	$2,687.50	$21.50	$2,266.25	$18.13
1959	2,661.25	21.29	2,183.75	17.47
1958	2,415.00	19.32	2,130.00	17.04
1957	2,581.25	20.65	2,172.50	17.38
1956	2,472.50	19.78	2,083.75	16.67
1955	2,275.00	18.20	1,935.00	15.48
1954	2,022.50	16.18	1,775.00	14.20
1953	2,097.50	16.78	1,695.00	13.56
1952	1,880.00	15.04	1,750.00	14.00
1951	1,915.00	15.32	1,692.50	13.54
1950	1,633.75	13.07	1,553.75	12.43
1949	1,465.00	11.72	1,447.50	11.58
1948	1,691.25	13.53	1,342.50	10.74
1947	1,606.25	12.85	1,262.50	10.10
1946	1,362.50	10.90	1,060.00	8.48
1945	1,315.00	10.52	876.25	7.01
1944	1,267.50	10.14	733.75	5.87
1943	1,057.50	8.46	648.75	5.19
1942	857.50	6.86	705.00	5.64
1941	750.00	6.00	657.50	5.26
1940	617.50	4.94	648.75	5.19
1939	598.75	4.79	705.00	5.64
1938	525.00	4.20	657.50	5.26
1937	585.00	4.68	693.75	5.55
1936	552.50	4.42	703.75	5.63
1935	478.75	3.83	707.50	5.66
1934	450.00	3.60	750.00	6.00
1933	375.00	3.00	717.50	5.74
1932	362.50	2.90	726.25	5.81
1931	455.00	3.64	801.25	6.41
1930	560.00	4.48	875.00	7.00
1929	647.50	5.18	863.75	6.91
1928	671.25	5.37	912.50	7.30
1927	723.75	5.79	925.00	7.40
1926	717.50	5.74	1,062.50	8.50
1925	713.75	5.71	1,065.00	8.52
1924	811.25	6.49	1,058.75	8.47
1923	925.00	7.40	1,007.50	8.06
1922	582.50	4.66	907.50	7.26
1921	905.00	7.24	933.75	7.47
1920	817.50	6.54	888.75	7.11

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